

**State of Connecticut
State Innovation Model Design
Care Delivery Work Group**

**July 22, 2013
Meeting Minutes**

Meeting Location: CT Behavioral Health Partnership, 500 Enterprise Drive, Rocky Hill

Members Present: Robert McLean (Co-Chairman); Mark Schaefer (Co-Chairman); Daren Anderson; Peter Bowers; Mehul Dalal; Meredith Ferraro; Jeffrey Howe; Gaye Hyre; Leah Jacobson; Dawn Johnson; Edmund Kim; Adam Mayerson; Michael Michaud; Susan Niemitz; Donna O'Shea; Laurel Pickering; Ron Preston; Lynn Rapsilber; Elsa Stone; Thomas Woodruff; William Young; Robert Zavoski

Members Absent: Alice Forrester; Sal Luciano; Rosemary Sullivan

Meeting convened at 6:10 p.m.

Discuss aspects of Connecticut and its new model that are distinctive

Members discussed strengths and opportunities in the state, including inequalities in health, high medical spend, concentration of health care leaders, strength in behavioral health in the public sector, engaged consumer base, cross-payer commitment, and variety of provider types. Additionally, the state has a foundation of technological advances it is proposing to build upon, such as the All Payer Claims Database (APCD).

The state will need to address challenges, including limited health information exchange capabilities today. The work group suggested that medical home adoption be referenced more directly as a point of distinction to demonstrate that the state is building on ongoing initiatives and is not starting from scratch.

The state employee value based health care program was also highlighted as a strength that other large employers in the state are emulating. It was noted that small and mid-sized employers are more hesitant to adopt value based programs because they do not see the benefit of them given employee turnover. The programs can make short term differences in terms of absenteeism but otherwise have a much longer return on investment which some employers do not expect to realize.

The group discussed additional challenges in the state. Connecticut residents tend to be reluctant to travel more than 10 minutes and operate within smaller geographic areas than those in other states. There are also those who live along state borders and travel to New York or Massachusetts for care which may limit in-state providers and health plan's ability to control costs. There are not enough providers in non-urban areas of state and it can be difficult to attract them because of the proximity to New York City and Boston. The state's primary care providers are aging, and medical leaders tend to be aged 55 and older. There may not be enough young providers to groom into leadership positions. There may also be some apathy towards change in the provider community with some providers not familiar with the concept of a medical home.

Consumer input from consumer engagement forums was shared with the group. It was shared that, in consumer forums, Medicare beneficiaries have expressed overall satisfaction with their healthcare though they have requested better vision, hearing, and dental coverage. Medicaid and uninsured consumers have expressed frustration over a perceived two tiered system. They also note that providers often do not listen or take the time to fully understand their needs. The Department of Social Services has made strides with its Medicaid medical home program but many clients still feel disenfranchised by the system. Also, there are those who go on and off Medicaid depending on their employment status and they have to change doctors every time they lose private insurance because not all providers accept Medicaid. This particularly problematic in the area of behavioral health where a client may have lost his/her job due to illness and now have to navigate a new health care system in addition to a new illness. One of the other concerns Medicaid clients have said is that they feel as if medical staff treat them like third class citizens. Members said these were concerns they needed to be mindful of going forward, so that a multi-tiered system of care is not perpetuated.

If there is a level playing field in terms of payment (Medicaid reimbursement on par with commercial), those issues may disappear. Community health workers may help as well as multiple programs in place that may not be well known. There is also a racial and ethnic component to disenfranchisement. The importance of understanding consumer's mindsets in designing a new care model was highlighted by reference to a study of people who tend to utilize the emergency room because it offered easy access and a known experience.

A work group member shared that signing national payers on to new payment models can be a challenge, as they are reluctant to put additional money into the system, and reluctant to make an upfront investment without a guarantee of return. The state may have similar concerns. Also, due to heavy patient loads, it may be difficult to educate doctors about a new payment system when there are issues with the existing one. There will be a need to provide them with specifics in order to encourage adoption.

Members also expressed the need to reinvest savings whenever possible and the need for learning collaboratives. There should be a focus on behavioral health as a source of major savings and improver of care. Other items that should be highlighted are engaging the consumer base, establishing patient portals and existing cross payer commitment. The group discussed how specialty care fits into the care model. This is something that is being examined on a national level, including NCQA developing guidelines. One of the prevailing principles remains patient empowerment. Primary care providers could sit with patients and discuss specialty care options.

Provide and discuss feedback on care delivery recommendations and level of personal and organizational support

The group discussed their level of support for a series of recommendations including the target populations; the key sources of value to address; what barriers need to be overcome; the behavioral/process interventions/changes required to capture sources of value; what roles need to be fulfilled to implement the interventions; and which entities are positioned to fulfill those roles. The payment reform work group has discussed the need for integrated provider structures to be established to ensure delivery of quality care, care coordination, and improved patient experience. The Payment Reform work group has not yet finished its work as its last meeting is scheduled for July 29th. It was emphasized that improving quality of care is essential to the model's success.

There was roundtable discussion from members as to whether they supported the model and what potential successes and concerns there were in the model that needed to be addressed. The

majority of work group members demonstrated support for the summary of the care delivery work group's recommendations. Highlighted as positives were person-centered/whole person care and integration of behavioral health; the development of the medical home; the increased use of community health workers; and evidence of success in value based care through the state employee health plan. Highlighted as concerns to be addressed were Title XIX clients remaining a second tier population with decreased access due to payment rates; the ability to gain enough savings to reinvest in the model; the need for improved information technology infrastructure; the need for malpractice reform; the need to effectively engage with consumers; the lack of "do no harm" language; the need for increased prevention beyond the pregnant women and newborn populations; and the need for patient/provider incentives. Members were concerned that there were not yet enough specific details available to judge how successful the model could be. There remain questions about how to pay for community health workers. It was suggested there may be flexibility in Medicaid permitting states to reimburse for preventive services provided by community health workers. There were questions as to how the system would be evaluated as a whole. There also needs to be defined linkage between the model and existing services.

Several members mentioned concerns about the support available for smaller practices to adopt the reforms without encouraging large-scale consolidation. It was asked how small practices can deliver coordinated care that is integrated with behavioral health. There may be practices that never move beyond pay for performance because they want to remain small. Educating providers on medical homes and what it will mean to be a medical home leader will also be crucial. Better analysis of data is also needed. There are providers who believe they don't make errors and there is no data to disprove them. It will also be important to try to meet consumers where they are at in order to raise their level of health. Overall, members were supportive of the framework established but were cautious about the amount of work that remained.

Discuss next steps for the work group

The appendix of the meeting discussion document includes feedback from work group members. Care Delivery members were encouraged to continue providing feedback and to share the model within their respective communities to generate awareness. The group reviewed the remaining work in the design phase to take place in August and September, as well as a high level roadmap for the next five years of the model. There may be conference call or in-person meetings with work group members down the road if it is determined their input is needed. There is continued work on a stakeholder engagement plan, which will be shared with work group members. It was suggested that the Connecticut State Medical Society's September meeting may be a good opportunity for outreach. Group members were thanked for their investment in the initiative and their work to develop a stage-setting model.

Meeting adjourned at 8:15.